Exhibit A

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
EASTERN DIVISION

WENDY CHICKAWAY, INDIVIDUALLY, AND AS ADMINISTRATOR and PERSONAL REPRESENTATIVE OF THE ESTATE OF BRANDON PHILLIPS, A MINOR, AND ON BEHALF OF ALL WRONGFUL DEATH BENEFICIARIES OF BRANDON PHILLIPS, DECEASED	§	
Plaintiffs	§	**CIVIL ACTION NO. 4:11-cv-00022-CWR-LRA**
v.	§	
UNITED STATES OF AMERICA	§	
Defendant	§	

DECLARATION OF DR. STEPHEN L. SHORE

I, Dr. Steven L. Shore, chief of pediatric infectious diseases at Scottish Rite Children's Hospital in Atlanta, Georgia, declare as follows, under penalty of perjury:

1. I have reviewed the medical records that you sent to me on Brandon Phillips, DOB 3/11/95, who died on 6/12107 from an overwhelming methicillin-sensitive staph aureus infection. He had a primary infection in his left ilium which led to fatal septicemia and multiple organ failure.
2. I am currently chief of pediatric infectious diseases at Scottish Rite Children's Hospital in Atlanta and clinical professor of pediatrics at Emory University School of Medicine. I am board certified both in general pediatrics and in pediatric infectious diseases. I have long experience with treating musculoskeletal infections especially those due to Staphylococcus aureus. I have seen at least one hundred invasive staph aureus infections

due to a primary focus in bones, joints and muscles in the last 10 years. I have attached my CV as Exhibit A.

3. Brandon presented to the Choctaw Indian Clinic on 4/5/07 with a history of left groin pain and pain in the upper left leg, along with tenderness to palpation of the left thigh. He was diagnosed with a muscle strain, given Toradol IM and told to take Motrin and apply ice. At that visit his vital signs were stable and he was afebrile. The care rendered at this visit was within acceptable limits.

4. He returned to the clinic at 12:45 on 4/07 at which time he was non-weight bearing. Although he was afebrile, he had a very elevated pulse of 150 with a repeat pulse taken later of 133. He was tender over the lateral and anterior hip and had diminished range of motion secondary to pain. He had also developed an erythematous rash on his arms. Plain X-rays were unrevealing, but a CT scan of his left hip and pelvis, showed asymmetry in the hip musculature. The radiologist suspected either bursitis or muscle tear. A CBC was done which showed a normal white blood cell count of 6100; however, there was a strong left shift with 95% segs, 3% lymphocytes, and 2% monocytes. The platelets were low normal at 157,000. Sed rate was elevated to 18.

5. He was sent home, although I could not find the record of a disposition in the clinical record. He was rushed to the Neshoba County Hospital on the following day, 4/8/07, at 0552 with difficulty breathing and continued severe pain in his left hip. At that time his pulse was 181, which is quite elevated, although his blood pressure was normal. His WBC had fallen to 700, which represents a severe leukopenia. He now had thrombocytopenia with a platelet count of 85,000. His BUN and creatinine were very elevated consistent with acute tubular necrosis. A blood culture was drawn which

subsequently grew methicillin-sensitive staph aureus. He was treated urgently both with Rocephin and vancomycin and then transferred to University Medical Center in Jackson, Mississippi by ambulance. Brandon continued to deteriorate while en route and before transfer to the University of Mississippi he had to be rerouted to Leake Memorial Hospital emergency department in Carthage to stabilize his clinical condition. At that point he was intubated and then airlifted to the University Medical Center. He was diagnosed with osteomyelitis of the left hip (iliac bone), septicemia, acute respiratory distress syndrome, and renal failure. He subsequently died in the PICU two months later on 6/12/07.

6. There was significant failure of the standard of care at his second visit to the clinic on 4/7/07. At that time Brandon showed very significant tachycardia with pulse rates of 150/minute and then 133/minute. He had also developed a rash on his arms, which is also suggestive of infection with organisms such as staph aureus or group A streptococci. His white count and differential were consistent with a severe or even overwhelming infection. The CT scan of his left hip and pelvis showed an abnormity. An MRI scan of the pelvis was also indicated as this is more sensitive than CT scan. Proper care would have included obtaining blood culture and then starting him on intravenous vancomycin and Rocephin given the fact that he was showing signs of toxicity from his infection. To meet the standard of care, be should have been transferred immediately to the University of Mississippi Medical Center. Instead, he was sent home and subsequently died due to the lack of care, especially broad spectrum antibiotics, over the next 17 bows. Based on my extensive experience with at least one hundred invasive staph aureus infectious during my 30 or more year career as an infectious disease specialist and especially during

the last 10-11 years when such invasive infections have been much more common, I can confidently say that in all probability Brandon would have survived bad he been given reasonable antibiotic treatment on 4/7/07 when he was in the clinic. Antibiotic therapy could have consisted of Rocephin alone rather than Rocephin and vancomycin, as his organism was methicillin sensitive.

Dated this 5th day of April, 2012.

Steven L Shore MD

Dr. Steven L. Shore